No. 86647-3

IN THE SUPREME COURT
OF THE STATE OF WASHINGTON

WASHINGTON STATE MEDICAL ASSOCIATION, a Washington nonprofit corporation, and WASHINGTON CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, a Washington nonprofit corporation,

Petitioners,

v.

MIKE KREIDLER, Washington State Insurance Commissioner,

Respondent.

PETITIONERS' REPLY BRIEF

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

I. INTRODUCTION

RCW 48.43.093 requires a health carrier to "cover" emergency services provided by an out-of-network provider, in certain circumstances, and limits the "differential cost-sharing" that the health carrier may impose on the patient, when such emergency services are provided by an out-of-network provider instead of an in-network provider, to fifty dollars. The parties dispute the meaning of this language.

Petitioners assert that this language requires the health carrier to pay all the costs associated with the emergency services the patient receives from an out-of-network provider, less what the patient would have had to pay had she obtained treatment from an in-network provider (and less an additional fifty dollars). The Insurance Commissioner asserts that this language requires the health carrier to pay only a portion of an out-of-network provider's charges, equivalent to what the health carrier would have paid had the services been provided by an in-network provider (less fifty dollars).

In other words, Petitioners' interpretation results in *the patient being in the same financial position* (or, at most, fifty dollars worse off) if she obtains emergency care from an out-of-network provider instead of an in-network provider, with her *insurer* responsible for the additional cost, whereas the Insurance Commissioner's interpretation results in *the insurer being in the same financial position* (or, if it chooses, fifty dollars better off) if the patient obtains emergency care from an out-of-network provider instead of an in-network provider, with the *patient* responsible for the

additional cost. Therefore, under the Insurance Commissioner's interpretation, *there is no* "differential cost-sharing," because *all* of the additional cost is the responsibility of the patient.

This case presents an important statutory-interpretation question which potentially affects everyone with health insurance in the state of Washington. Contrary to the Insurance Commissioner's contention, this issue is properly before the Court and the Court should issue a declaratory judgment resolving it at this time. This would eliminate the current confusion regarding what level of emergency coverage is mandated by the statute, and allow the Insurance Commissioner, health carriers, policyholders, and patients statewide to proceed based on a correct understanding of what the law requires.

II. ARGUMENT

A. Petitioners' interpretation of the statute is correct.

1. The Court should interpret the statute consistently with its plain meaning.

"In any question of statutory construction," the Court "look[s] to ascertain the intention of the legislature by first examining a statute's plain meaning. Statutes must be interpreted and construed so that all the language used is given effect, with no portion rendered meaningless or superfluous. If the statute's meaning is plain on its face, then the court must give effect to that plain meaning as an expression of legislative intent. Plain meaning is discerned from the ordinary meaning of the language at issue, the context of the statute in which that provision is

found, related provisions, and the statutory scheme as a whole." *State v. Hirschfelder*, 170 Wn.2d 536, 543, 242 P.3d 876 (2010) (citations and internal quotation marks omitted).

2. The statute requires a health carrier to "cover" emergency services.

The statute states that "[a] health carrier shall *cover* emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency condition existed." RCW 48.43.093(1)(a) (emphasis added). "Cover" is not defined in the statute. When a word is not defined in a statute, the Court "may look to the dictionary" in order "to determine its plain meaning[.]" *In Re Danforth*, 173 Wn.2d 59, 67, 264 P.3d 783 (2011).

"Various dictionaries indicate that to 'cover' in the context of costs means an amount sufficient to *pay all the costs*." *Cal. Alliance of Child and Family Servs. v. Allenby*, 589 F.3d 1017, 1021 (9th Cir. 2009) (citations omitted; emphasis added). This dictionary definition "comports with the common understanding of what it means to 'cover the cost.'" *Id.* "[T]he natural meaning of 'cover the cost' is to pay in full, not in part." *Id.* at 1018. Because the Legislature did not define "cover" for purposes of RCW 48.43.093, the Court should assume that the Legislature intended to use this word consistently with the common, dictionary definition, *i.e.*, that a health carrier's obligation to "cover" emergency services means it must "pay all the costs" of emergency services.

3. The statute requires a health carrier to cover emergency services even when provided by an out-of-network provider.

The statute further states that a health carrier "shall cover emergency services necessary to screen and stabilize a covered person" even when provided by a nonparticipating provider, "if a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility." RCW 48.43.093(1)(a).

The reason this provision is necessary—*i.e.*, the reason why a health carrier might not otherwise "cover" emergency services provided by a *nonparticipating* provider—is that the full, "billed" charges of a nonparticipating provider are likely to be higher than the discounted, "allowed" charges negotiated between a health carrier and its network providers.

Using the common, dictionary definition of the word "cover," this provision requires the health carrier to "pay all the costs" of the emergency services provided by a nonparticipating provider (*i.e.*, the charges "billed" to the patient), even though these likely will be higher than the costs would have been had the services been provided by a participating provider (*i.e.*, the charges "allowed" by the insurer).

4. The statute allows the health carrier to shift only fifty dollars of the differential cost to the patient.

Finally, the statute states that "[c]overage of emergency services may be subject to applicable copayments, coinsurance, and deductibles,

and a health carrier may impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers, if such differential between cost-sharing amounts applied to emergency services rendered by participating provider versus nonparticipating provider does not exceed fifty dollars." RCW 48.43.093(1)(c). In other words, the health carrier may shift to the patient a maximum of fifty dollars of the additional cost if the services are provided by a nonparticipating provider.

5. Petitioners' interpretation of the statute is consistent with its plain meaning.

Petitioners' interpretation of the statute is consistent with its plain meaning. A health carrier must cover certain emergency services. It must do so even if the services are provided by a nonparticipating provider, if the delay in obtaining care from a participating provider would have worsened the emergency. And, it may shift to the patient only fifty dollars of the differential cost between what the nonparticipating provider billed and what the insurer would have paid to a participating provider.

6. The Insurance Commissioner's criticisms of Petitioners' plain-meaning interpretation are not well-founded.

The Insurance Commissioner argues that the statute cannot mean that health carriers must pay nonparticipating providers' billed charges because the statute is "silent" regarding "the amounts that health providers are permitted to charge." Insurance Commissioner's Response Brief ("Resp. Br.") at 27-28. However, Petitioners are not arguing that the statute determines how much physicians may charge; rather, the statute

determines the allocation of the physician's charges between the patient and her insurer. Specifically, the statute provides that in certain, emergency situations, a patient may obtain care from a nonparticipating provider and her health carrier must bear the additional cost of this.

The Insurance Commissioner also argues that the fifty-dollar limit on the "differential cost-sharing" which the health carrier may impose on the patient applies *only* to the differences between the copayments, coinsurance, and deductibles imposed by the health carrier with respect to nonparticipating providers *vis-à-vis* participating providers. *See* Resp. Br. at 28-30. However, it does not follow, as the Insurance Commissioner suggests, that the health carrier may shift to the patient the entire difference between the billed charges incurred by the patient treated by a nonparticipating provider and what the allowed charges would have been had the patient been treated by a participating provider.

The Insurance Commissioner's interpretation cannot be reconciled with the language of the statute, which requires a health carrier to "cover" emergency services, in the circumstances contemplated by the statute, regardless of whether they are provided by a participating or nonparticipating provider. *See* RCW 48.43.093(1)(a). To adopt the Insurance Commissioner's interpretation of the statute, the Court would have to ignore the ordinary meaning of "cover"—*i.e.*, to "pay all the costs"—and instead interpret "cover" to mean "to pay a portion of the costs."

Finally, the Insurance Commissioner's interpretation would result in a health carrier paying *less* when treatment is provided by a nonparticipating provider than when treatment is provided by a participating provider, because the insurer may shift to the patient the entire difference between the nonparticipating provider's billed charges and what a participating provider's allowed charges would have been. In other words, *there would be no* "differential cost-sharing," because *all* of the differential cost would be the responsibility of the patient.

B. The Insurance Commissioner's interpretation is inconsistent with the language of the statute, the policy underlying the statute, and his office's past practice.

The Insurance Commissioner emphasizes that courts generally give deference to an agency's interpretation of statutes and regulations. Resp. Br. at 33-35. "An agency's interpretation of an ambiguous statute *is not entitled to deference*, however, if the interpretation is not within the agency's area of expertise, or *if the interpretation is entirely inconsistent with the agency's prior administrative practice.*" *Skamania County v. Columbia River Gorge Comm'n*, 144 Wn.2d 30, 43, 26 P.3d 241 (2001) (citations omitted; emphasis added). Moreover, "the court is the final authority on statutory construction and it need not approve regulations or decisions inconsistent with a statute or *the policy underlying the statute.*" *Moses v. State*, 90 Wn.2d 271, 274, 581 P.2d 152 (1978) (emphasis added). Applying these principles here, the Court should not give deference to the Insurance Commissioner's interpretation of RCW 48.43.093.

1. The Insurance Commissioner's interpretation is inconsistent with the language of the statute.

The Insurance Commissioner's interpretation is inconsistent with the language of the statute. As discussed above, the Insurance Commissioner's interpretation would require the word "cover" to mean "to pay in part," rather than the ordinary, dictionary definition of "pay in full." It also would render meaningless the fifty-dollar limit on "differential cost-sharing," because the entire difference would be the responsibility of the patient.

2. The Insurance Commissioner's interpretation is inconsistent with the policy underlying the statute.

Additionally, the Insurance Commissioner's interpretation is inconsistent with the policy underlying the statute. As discussed above, the Insurance Commissioner's interpretation would allow insurers to shift all of the additional cost of a nonparticipating provider *vis-à-vis* a participating provider to the patient, which will discourage patients from obtaining care from the closest emergency room, which was a fundamental goal of this legislation and the subject of the public information campaign which followed its adoption. CP 467-69. The Insurance Commissioner's interpretation also would provide no incentive for health carriers to expand their networks of emergency providers.

3. The Insurance Commissioner's interpretation is inconsistent with his office's past practice.

As discussed in Petitioners' opening brief, the Insurance Commissioner's current interpretation of the statute contradicts his office's historic interpretation of the statute. Indeed, the Insurance

Commissioner's change of position is recognized in internal Office of the Insurance Commissioner ("OIC") documents. CP 607 (characterizing the Insurance Commissioner's interpretation as the office's "new position"); *see also* CP 497 (declaration of a deputy insurance commissioner, explaining that the Insurance Commissioner changed his office's position as a result of activities of Premera).

The Insurance Commissioner now attempts to defend his new interpretation based on the language of the statute, specifically by arguing that health carriers are permitted to shift to patients the difference between a nonparticipating provider's billed charges and what the insurer has agreed to pay to its participating providers, notwithstanding the fifty-dollar limit on "cost-sharing."[1]

More importantly, the Insurance Commissioner's new explanation is contradicted by his office's internal correspondence regarding this issue. Deputy Insurance Commissioner Elizabeth Berendt posed the following question to OIC attorney Charles Brown:

> The statute says differential for non-participating hospital emergency departments may apply if limited to $50. However, *does that include the balance billed amount (or just the difference for copayments, coinsurance and deductibles)* [?]

CP 605 (emphasis added). Mr. Brown advised her as follows:

> ... Accordingly, I read the statute to mean that *the cost to the enrollee of going to a non-par[ticipating] ER cannot be more than fifty dollars over what it would have been if the enrollee had gone to a contracted ER.* I[t] appears to me

[1] The Insurance Commissioner does not explain what portion of the billed charges a health carrier must pay if it pays different rates to different in-network providers.

> this $50 differential limit includes whatever amount is balanced billed as well as any coinsurance or deductible liability on the part of the enrollee, so that *the enrollee's deductible, copay, and balance bill are all added up and compared to the total that the enrollee would have paid at a par[ticipating] ER, with the enrollee paying a maximum of that amount plus $50 and the carrier paying the rest of the non-par[ticipating] ER's billed charges. ...*

CP 604 (emphasis added). Therefore, the OIC staff explicitly rejected, internally, the precise legal argument which the Insurance Commissioner now attempts to advance.

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In summary, the Court should not defer to the Insurance Commissioner's interpretation of the statute; the Insurance Commissioner's interpretation is inconsistent with the language of the statute, the policy underlying the statute, and his office's past practice; Petitioners' interpretation is consistent with legislative intent, as shown through the plain meaning of the statutory language; and Petitioners are entitled to summary judgment on this issue of law.

C. The Court should issue a declaratory judgment interpreting the statute.

The Insurance Commissioner offers several reasons why, in his view, the Court should not interpret RCW 48.43.093. We will address each of these arguments in turn.

1. Health carriers are not necessary parties to Petitioners' declaratory judgment claim against the Insurance Commissioner.

The Uniform Declaratory Judgments Act (the "UDJA") provides that "[w]hen declaratory relief is sought, all persons shall be made parties

who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding." RCW 7.24.110. Because the trial court determined that "a health carrier" is a necessary party under this standard, it dismissed Petitioners' declaratory-judgment claim. CP 618-19.

The Insurance Commissioner appears to concede that it is not necessary to join *every* health carrier as a party. However, the Insurance Commissioner had to make this concession, in light of the Court's previous opinions interpreting provisions of the Insurance Code without joining every affected insurer as a party. *See, e.g., Hodge v. Raab*, 151 Wn.2d 351, 358, 88 P.3d 959 (2004) (interpreting Insurance Code provision relating to motor vehicle insurance, without requiring that all car insurance companies be joined as parties). Nevertheless, the Insurance Commissioner argues that "at least one" health carrier must be joined as "representative" of health carriers' interests. Resp. Br. at 17.

The reason Petitioners brought this case against the Insurance Commissioner alone is because the current confusion over the scope of coverage required under RCW 48.43.093 was created by the Insurance Commissioner changing his position regarding what RCW 48.43.093 requires, and accordingly changing his directions to health carriers. Petitioners are not seeking any relief against health carriers who presumably are following the direction of the Insurance Commissioner regarding what level of coverage they are required to provide. Instead, Petitioners are seeking relief against the Insurance Commissioner, the

person who is required by law to enforce RCW 48.43.093, but currently is not doing so as a result of his misinterpretation of the statute.

The Insurance Commissioner relies upon the Court of Appeals' opinion in *Bainbridge Citizens United v. Wash. State Dep't of Natural Res.*, 147 Wn. App. 365, 198 P.3d 1033 (2008), but that case actually illustrates why health carriers are *not* necessary parties in the present case.

In *Bainbridge Citizens United*, the petitioner sought "an order declaring that" certain non-parties were "in violation of" certain regulations and that the agency had a duty to take specific enforcement actions against the non-parties. *See Bainbridge Citizens United*, 147 Wn. App. at 372-73. Because the non-parties were the only persons who could rebut the petitioner's factual allegations that they had violated the regulations at issue and the declaration would be that the non-parties had violated the regulations, the court determined that they were necessary parties. *See id.* at 373-74.

The present case is not analogous. Here, Petitioners do not seek a declaration that any insurer violated RCW 48.43.093 or that the Insurance Commissioner is required to take specific enforcement action against any insurer. Petitioners simply are seeking the interpretation of a statute.

2. The parties have a justiciable dispute.

For the Court to issue a declaratory judgment, there must be a "justiciable controversy" between the parties. This requires (1) an actual, present and existing dispute, or the mature seeds of one; (2) between parties having genuine and opposing interests; (3) which involves interests

that are direct and substantial; and (4) a judicial determination of which will be final and conclusive. *See Diversified Indus. Dev. Corp. v. Ripley*, 82 Wn.2d 811, 815, 514 P.2d 137 (1973). Each of these requirements is satisfied here.

a. There is an actual, present, and existing dispute.

With respect to the first justiciability requirement, there is an actual, present, and existing dispute between Petitioners and the Insurance Commissioner. Specifically, the parties dispute whether RCW 48.43.093 requires health carriers to bear the additional cost when emergency services are provided by nonparticipating providers or whether health carriers can shift this cost to patients. Statutory-interpretation disputes are among the types of disputes for which the UDJA is intended. *See* RCW 7.24.020.

The Insurance Commissioner argues that there is not an "actual" dispute between Petitioners and the Insurance Commissioner because nonparticipating providers can "balance-bill" their patients for the difference between their billed charges and what health carriers pay, and therefore the Insurance Commissioner's interpretation of the statute only affects patients, not healthcare providers. *See* Resp. Br. at 18. As Petitioners alleged in their amended complaint, however, healthcare providers also are harmed by the Insurance Commissioner's interpretation of the statute. This harm includes (1) the additional cost and effort required to balance-bill and collect payment directly from patients; (2) lower reimbursement for services, where such collection efforts are not

made or are unsuccessful; and (3) the adverse impact on the doctor-patient relationship that may result from balance-billing. CP 438-39.

There is no inconsistency, contrary to the Insurance Commissioner's assertion, between (1) Petitioners' acknowledgement that in theory they could receive full payment by balance-billing and collecting from every patient and (2) Petitioners' recognition that in the real world they will not balance-bill every patient and will not succeed in collecting every time they do balance-bill. *See* Resp. Br. at 18.

Moreover, even assuming, for the sake of argument, that nonparticipating providers could successfully balance-bill and collect from every patient, there would still be an actual, present, and existing dispute between Petitioners and the Insurance Commissioner regarding the interpretation of the statute, and the resolution of that dispute will affect how nonparticipating providers conduct their professional activities (*i.e.*, how they bill for their services) and their relationships with their patients (*i.e.*, the effect of balance-billing on those relationships).

b. The parties have genuine and opposing interests.

With respect to the second justiciability requirement, Petitioners and the Insurance Commissioner have genuine and opposing interests in this matter. Petitioners' interest is in the Court determining that RCW 48.43.093 requires health carriers to cover the full cost of emergency services provided by nonparticipating providers, which will result in better reimbursement of emergency physicians and prevent the harm to the doctor-patient relationship resulting from balance-billing and collection

efforts regarding such bills. The Insurance Commissioner's interest, in contrast, is in the Court determining that RCW 48.43.093 only requires health carriers to cover a portion of nonparticipating providers' charges, equivalent to what health carriers would pay to their participating providers, a limitation which the Insurance Commissioner apparently believes will contribute to "a healthy and robust health insurance market." CP 488.

c. The parties' interests are direct and substantial.

With respect to the third justiciability requirement, Petitioners' interests are direct and substantial. The Insurance Commissioner's new position regarding what RCW 48.43.093 requires (1) harms the relationship between emergency physicians and their patients; (2) imposes burdens on emergency physicians which would not otherwise exist; and (3) results in emergency physicians receiving lower reimbursement. The Insurance Commissioner's interests also are direct and substantial, for the reasons discussed above.

Branson v. Port of Seattle, 152 Wn.2d 862, 101 P.3d 67 (2004), cited by the Insurance Commissioner, is inapposite. In that case, a customer of a rental-car company challenged the fees charged by the Port to the rental-car company. However, there was no relationship between the Port and the customer. Although rental-car companies certainly had the prerogative to raise the prices charges to their customers to reflect these fees, they were not required to do so. Accordingly, the court

determined that the customer and the Port were "not sufficiently opposed" to satisfy the third justiciability requirement. *Branson*, 152 Wn.2d at 878.

The present case is not analogous to *Branson*. Whether the Insurance Commissioner requires health carriers to pay nonparticipating providers' full charges directly impacts Petitioners' members, both in terms of how much they are reimbursed and from whom they will receive payment. Therefore, emergency physicians do have a direct and substantial interest regarding the level of coverage mandated by RCW 48.43.093.

d. A determination by the Court of the correct interpretation of RCW 48.43.093 will be final and conclusive.

With respect to the fourth justiciability requirement, the Insurance Commissioner argues that the Court's issuance of a declaratory judgment interpreting RCW 48.43.093 in this case would not resolve the statutory interpretation issue with finality, because the correct interpretation of the statute could be re-litigated by health carriers, policyholders, and providers who are not parties to this case. *See* Resp. Br. at 19-20. As a practical matter, the issue is unlikely to arise again, because health carriers will write policies, and the Insurance Commissioner will only approve policies, which comport with Washington law as interpreted by this Court. Even if the issue were raised in a future proceeding, however, the Court's interpretation of the statute in this case would be binding precedent. *See Riehl v. Foodmaker, Inc.*, 152 Wn.2d 138, 147, 94 P.3d 930 (2004) ("[W]here statutory language remains unchanged after a court decision the

court will not overrule clear precedent interpreting the same statutory language.").

3. The Court's interpretation of the statute will not be an "advisory opinion."

The Insurance Commissioner argues that if the Court were to issue a declaratory judgment interpreting RCW 48.43.093, this would be an impermissible "advisory opinion." To the contrary, the UDJA explicitly contemplates that courts will issue declaratory judgments interpreting statutes. The Court only "steps into the prohibited area of advisory opinions" if "the four justiciability factors are *not* met[.]" *To-Ro Trade Shows v. Collins*, 144 Wn.2d 403, 416, 27 P.3d 1149 (2001) (citation omitted; emphasis added). Because the four justiciability factors *are* met in this case, for the reasons discussed above, the Court would not be offering an "advisory opinion" by granting summary judgment on Petitioners' declaratory-judgment claim and issuing a declaratory judgment interpreting RCW 48.43.093.

4. Healthcare providers have standing to seek a declaratory judgment regarding the interpretation of the statute.

The Insurance Commissioner's argument that Petitioners lack standing to bring this suit "on behalf of the policyholder patients," Resp. Br. at 20, is a red herring. It is true that the Insurance Commissioner's position harms policyholders and patients. However, Petitioners are not asserting their declaratory-judgment claim on behalf of policyholders or patients; rather, Petitioners are asserting this claim on their own behalf.

CP 439 (Amended Complaint, stating that "action is brought by providers, rather than policyholders").

Petitioners have standing to seek a declaratory judgment regarding the interpretation of RCW 48.43.093 on their own behalf. The standing requirement to bring a claim under the UDJA is as follows: "A person ... whose rights, status or other legal relations are affected by a statute ... may have determined any questions of construction or validity arising under the ... statute ..." RCW 7.24.020.

Petitioners have standing under the UDJA standard. The "legal relations" of Petitioners' members are "affected" by RCW 48.43.093, as that statute provides either (1) that insurers must pay all costs of nonparticipating providers or (2) that insurers must pay only a portion of the costs of nonparticipating providers, with patients liable for the difference. This affects, *inter alia*, how and whom Petitioners' members must bill for their services, and how much they will be reimbursed.[2]

The Insurance Commissioner also argues that in addition to the standing requirement set forth in the UDJA itself, Petitioners must demonstrate that their claim relates to the "zone of interests" regulated by RCW 48.43.093. In the case relied upon by the Insurance Commissioner, *To-Ro Trade Shows*, the Court held that "to *challenge the constitutionality*

[2] Petitioners have representational standing to bring this suit on behalf of their members because their members would have standing to sue in their own right; the interests Petitioners seek to protect are germane to the organizations' purposes, and neither the claims asserted nor the relief requested require participation of individual members in the lawsuit. *See Am. Legion Post #149 v. Wash. State Dep't of Health*, 164 Wn.2d 570, 595, 192 P.3d 306 (2008).

of a statute" a party must show that its interest relates to "the zone of interests to be protected or regulated by the statute or constitutional guarantee in question." *To-Ro Trade Shows*, 144 Wn.2d at 414-15 (citation omitted; emphasis added) (holding that plaintiff's "financial interest as a show promoter clearly does not coincide with the statute's aim of protecting consumers from fraudulent or abusive conduct by vehicle dealers" and that because the plaintiff "is not within the zone of interests regulated" in the applicable statute, "it lacks standing to challenge the statute on First Amendment grounds[.]"). Because Petitioners are not challenging the constitutionality or validity of RCW 48.43.093, but instead are seeking the interpretation of the statute, it is not apparent that this analysis is applicable in this case.

However, even if the zone-of-interests standard applies in this case, Petitioners satisfy it. RCW 48.43.093 requires insurers to pay for emergency services. Emergency physicians' financial interest in such payments, as well as emergency physicians' interest in protecting their relationships with their patients from the adverse effects of balance-billing and collection efforts regarding such bills, are the types of "interests" which fall within the "zone" of what the statute at issue "regulates." *See Biggers v. City of Bainbridge Island*, 124 Wn. App. 858, 864, 103 P.3d

244 (2004) (business owners had standing to challenge validity of shoreline-development moratorium).[3]

5. The Court may award summary judgment to Petitioners on the merits even though the trial court erroneously determined that it lacked jurisdiction.

The trial court granted summary judgment in favor of the Insurance Commissioner because it erroneously determined that it lacked jurisdiction to hear this case. CP 618-19. However, had the trial court rejected the Insurance Commissioner's argument below, it could have granted summary judgment in favor of Petitioners. *See State Health Ins. Pool v. Health Care Auth.*, 129 Wn.2d 504, 507, 919 P.2d 62 (1996) (affirming trial court's *sua sponte* award of summary judgment to non-moving party). Similarly, if this Court reverses the trial court's decision, it may grant summary judgment in favor of Petitioners. *See Barber v. Peringer*, 75 Wn. App. 248, 255, 877 P.2d 223 (1994) (remanding for summary judgment to be entered in favor of non-moving party). For purposes of this analysis, it makes no difference that the Insurance Commissioner's motion was originally filed as a CR 12 motion to dismiss. Because the trial court treated the motion as a CR 56 motion and granted summary judgment to the Insurance Commissioner, this Court reviews the trial court's decision *de novo*, just as it would any other summary

[3] Even if the question of Petitioners' standing were debatable, the Court still should consider the statutory-interpretation issue here because it involves "significant and continuing matters of public importance that merit judicial resolution." *Am. Traffic Solutions, Inc. v. City of Bellingham*, 163 Wn. App. 427, 433, 260 P.3d 245 (2011).

judgment order. *See Kelley v. Centennial Contractors Enterprises, Inc.*, 169 Wn.2d 381, 385-86, 236 P.3d 197 (2010).

The Insurance Commissioner argues that because the trial court did not decide the statutory-interpretation issue on the merits, this Court should decline to do so as well. *See* Resp. Br. at 24-25. The cases cited by the Insurance Commissioner are inapposite, however.

In *Dep't of Ecology v. Acquavella*, 131 Wn.2d 746, 935 P.2d 595 (1997), which involved a determination of water rights, the legal issue that was "not ripe" was whether an irrigation district could rely upon a subsection of the Water Code, RCW Chapter 90.03, as an excuse for non-use of water. The issue was not ripe because the trial court had not determined, as a factual matter, that the irrigation district had forfeited a portion of its water right through non-use; unless and until such a determination were made, there would be no need to determine whether the statute excused such non-use. *See Acquavella*, 131 Wn.2d at 759-60.

Similarly, in *W.R. Grace & Co. v. State*, 137 Wn.2d 580, 973 P.2d 1011 (1999), which involved the application of Washington's B&O tax to interstate manufacturers and sellers, the issues that were "not ripe" were standing and claim-preclusion arguments relating to particular taxpayers, which appear to have been contingent upon factual determinations which the trial court had not yet made. *See W.R. Grace & Co.*, 137 Wn.2d at 592.

Here, in contrast, there are no factual determinations which the trial court must make. This case presents only issues of law: (1) how

RCW 48.43.093 should be interpreted (declaratory-judgment claim) and (2) whether the Insurance Commissioner is required to enforce the statute consistently with the correct interpretation (mandamus claim).

The trial court awarded summary judgment to the Insurance Commissioner on both of Petitioners' claims. The fact that the trial court relied upon one narrow ground in doing so (its determination that Petitioners must join at least one health carrier as a party to state a claim under the UDJA) does not mean that this Court cannot consider other grounds, supported by the record, why the Insurance Commissioner may be entitled to summary judgment—*and* grounds why the non-moving parties below, Petitioners, may be entitled to summary judgment instead.

6. This case presents pure issues of law.

The Insurance Commissioner argues that there is an insufficient evidentiary record for the Court to resolve the parties' statutory-interpretation dispute. *See* Resp. Br. at 25-26. However, the interpretation of a statute is an issue of law. The Insurance Commissioner's suggestion that to interpret this statute, a court would need to take "evidence" as to how insurers "would be affected" by various interpretations of the statute, is mistaken. *See* Resp. Br. at 26. The role of the Court is to state what the language of the statute means, not to make evidentiary findings regarding the statute's effects.

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In summary, Petitioners have standing to bring a declaratory-judgment claim against the Insurance Commissioner; Petitioners may

bring this claim against the Insurance Commissioner alone, without joining any additional parties; there is a justiciable claim between Petitioners and the Insurance Commissioner regarding the interpretation of the statute; the statutory-interpretation issue is ripe for resolution by this Court; and the Court may properly resolve this issue on the merits even though the trial court did not do so.

D. The Court should issue a writ of mandamus to the Insurance Commissioner to enforce the statute consistently with the correct interpretation.

1. Petitioners' mandamus claim is not contingent upon Petitioners' declaratory-judgment claim.

The trial court concluded that if Petitioners did not satisfy the requirements to bring a claim under the UDJA, they also could not seek a writ of mandamus against the Insurance Commissioner. CP 623. This was error. A declaratory-judgment claim is not a prerequisite to bring a mandamus claim. Therefore, even if the Court affirms the trial court's dismissal of Petitioners' declaratory-judgment claim, it still may grant summary judgment to Petitioners on their mandamus claim.

2. Petitioners are entitled to summary judgment on their mandamus claim.

A writ of mandamus may be issued "to compel the performance of an act which the law especially enjoins as a duty resulting from an office, trust or station[.]" RCW 7.16.160. A writ of mandamus may be issued only to compel a "*ministerial*" duty, which is synonymous with a "nondiscretionary" duty. *SEIU Healthcare 775NW v. Gregoire*, 168 Wn.2d 593, 599, 229 P.3d 774 (2010). The Insurance Commissioner's

"ministerial" or "nondiscretionary" duty at issue here is to correctly interpret RCW 48.43.093, a statute the Insurance Commissioner is required to enforce.

There is no dispute that the Insurance Commissioner must enforce RCW 48.43.093. *See* RCW 48.02.060(2) ("The commissioner *must* ... enforce the provisions of this code.") (emphasis added). There also is no dispute that the Insurance Commissioner has discretion regarding what specific types of enforcement actions to take. *See* RCW 48.02.060(3) ("The commissioner *may*" take various actions) (emphasis added).

The Insurance Commissioner appears to believe that he has discretion not only regarding how to enforce RCW 48.43.093, but also how to *interpret* RCW 48.43.093. This explains his change of position regarding the meaning of the statute, apparently based on the changing practices of one health carrier. It also is the reason why a writ of mandamus is necessary. The Insurance Commissioner is required to enforce the statute consistently with its actual meaning.

3. Petitioners were not required to seek relief under the Administrative Procedure Act.

The Insurance Commissioner argues that instead of seeking a writ of mandamus, Petitioners should have sought judicial review, under the Administrative Procedure Act (the "APA"), of the Insurance Commissioner's failure to enforce RCW 48.43.093 consistently with its actual meaning. Resp. Br. at 40-41 (citing RCW 34.05.570).

Under RCW 7.16.360, a writ of mandamus may not be sought with respect to "state agency action reviewable under" the APA. However, the applicable provision of the APA states that only "*[a] person whose rights are violated* by an agency's failure to perform a duty that is required by law to be performed may file a petition for review[.]" RCW 34.05.570(4)(b) (emphasis added). Petitioners have never asserted that their "rights" were violated by the Insurance Commissioner's misinterpretation of RCW 48.43.093, and the Insurance Commissioner fails to explain how Petitioners could have invoked this provision of the APA. Petitioners assert only that the Insurance Commissioner has a duty to enforce the statute consistently with the correct interpretation, and the Court should issue a writ of mandamus to compel him to do so.

III. CONCLUSION

Petitioners respectfully request that the Court reverse the trial court's decision; issue a declaratory judgment interpreting RCW 48.43.093; and issue a writ of mandamus to the Insurance Commissioner to enforce the statute consistently with the correct interpretation.

Respectfully submitted this 13th day of April 2012.

PERKINS COIE LLP

By: _____
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Attorneys for Petitioners,
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CERTIFICATE OF SERVICE

I, Andrea Lockwood, certify under penalty of perjury under the laws of the State of Washington that today I caused to be served the foregoing *Petitioners' Reply Brief* on the following persons by e-mail, pursuant to the parties' agreement regarding service by e-mail:

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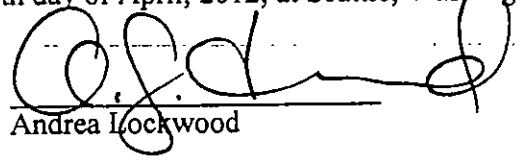
Signed this 13th day of April, 2012, at Seattle, Washington.



Andrea Lockwood

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Cc: jeanw@atg.wa.gov; martad@atg.wa.gov; meghanl@atg.wa.gov; Grimm, Brian W. (Perkins Coie)
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Good afternoon:

Attached please find Petitioners' Reply Brief for email filing with the court.

Please see below for the required information pursuant to your email filing protocol.

- **Case name:** WASHINGTON STATE MEDICAL ASSOCIATION, a Washington nonprofit corporation, and WASHINGTON CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, a Washington nonprofit corporation v. MIKE KREIDLER, Washington State Insurance Commissioner.
- **Case number:** 86647-3
- **Attorney information:** Brian W. Grimm, WSBA No. 29619
  Phone: 206.359.8000
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Please let me know if you have any questions or need any additional information. I look forward to receiving your confirmation of filing.

Thank you,

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